

*From Representative Jason Smith of Missouri:*

Question 1:

Dr. Boustany has a bill that I would like to highlight, because it hits the prevention side of the tax code and could help encourage physical activity.

The Personal Health Investment Today, or PHIT Act would make it easier for people to be physically active. The PHIT Act would allow people to use their HSAs and FSAs for certain sports and fitness expense, like gym memberships, athletic league dues, and sports and fitness equipment used exclusively for participation in physical exercise.

In other words, we would use the tax code to encourage active, healthy activities.

Mr. Antos— do you see a benefit to working towards reducing our long-term health care costs with such policy investments on the front end?

Do you have any ideas of various other policies that we might want to consider to help reduce the barriers to entry in these struggling, mostly low-income, areas for physical activity?

**Response: We have become a largely sedentary society, which has led to an increasing incidence of obesity and chronic diseases that could be prevented if we became more physically active. One barrier to physical activity is personal: we have to make the time and effort to take a walk or engage in some other activity. It is important to instill in our children an enthusiasm for sports or other physical activities that they can engage in over their lifetimes. School programs can help, but children follow the lead of their parents. A parent who is active sets an example for his or her children that they can follow. Financial barriers can also discourage healthy physical activity. Allowing people to use some of their HSA/FSA funds for sports and fitness expenses can help, but the success of such a policy would depend on the individual taking the initiative to engage in physical activities. People in low-income areas may not be able to make substantial contributions to an HSA/FSA. For them, local communities could invest in community sports and fitness facilities, offering free or reduced-cost memberships.**

Question 2:

Thank you for holding this important hearing, Mr. Chairman. Our tax treatment of health care can and must be improved.

Under current law, starting in 2018, the “Cadillac Tax” will equal 40 percent of the costs of employer contributions to health benefits above a certain threshold.

Time and time again I hear from employers all across South and Southeastern Missouri that the Cadillac tax suppresses their ability to raise wages and properly compensate their employees.

Some folks across the aisle have made it clear that they have an answer to the ESI exclusion: the Cadillac Tax.

Democrats will say, “The Cadillac Tax already does limits to exclusion.” Some might ask why we won’t work with Democrats to fix the tax instead of all this replace nonsense?

The reality is that the Cadillac tax is a crude, complex, and flawed policy.

And it – like the rest of the Presidents' health care law – must be replaced.

But we can improve upon the concept of the Cadillac Tax to actually target high cost employer-provided plans, protect the employer-sponsored market and limit an open-ended tax benefit that increased premiums and suppresses wage growth.

Mr. Antos, can you walk us through some of the shortcomings of the Cadillac Tax?

What would be a simpler and less administratively costly way to limit some of the negative effects of the ESI exclusion while maintaining the popular employer-sponsored health care system generally?

Ultimately, who does JCT project will be responsible for the Cadillac Tax? Who ends up picking up the tax and being burdened by it the most?

**Response: The Cadillac tax is a 40 percent excise tax on employment-based health benefits that exceed specified cost thresholds. Although the tax is nominally paid by employers, insurers, and other health plan sponsors, the cost will be borne by the workers. If the employer or plan sponsor cuts back benefits to avoid the tax, then workers will face higher health costs and restricted access to physicians and other providers. If the employer does not cut back benefits, then the tax will be paid by workers through higher premiums.**

**Problems with the Cadillac tax include the following:**

- **Low-wage workers and those living in high-cost areas (such as New York City or San Francisco) are most disadvantaged by the Cadillac tax. Low-wage workers have less financial ability to absorb the higher costs that will be shifted to workers. In addition, the tax's thresholds do not account for geographic variations in the cost of health care, which means that a worker in a high-cost area is more likely to be affected by the tax than one in a low-cost area.**
- **The Cadillac tax undercuts the use of health savings accounts (HSAs), which promote prudent purchasing of health care services. All contributions to HSAs count toward the threshold limits set by the law.**
- **The Cadillac tax will eventually impact everyone with employer coverage. The cost thresholds are indexed to general inflation. Because health care costs generally rise much faster than that, eventually all employer health plans will exceed what the ACA considers acceptable levels of health care coverage.**
- **The Cadillac tax imposes new reporting requirements on employers and insurers, and creates new costs of enforcement and tax collection.**

**A better alternative to the Cadillac tax is to cap or limit the amount of employment-based health benefits that can be excluded from a worker's income. Capping the exclusion would promote the purchase of more efficient health coverage while retaining incentives for employers to offer coverage to their employees. The cap would encourage employers to seek lower-cost plan options, but would not drive employers to offer only low-cost plans. The cap could be tied to the actual cost of health insurance rather than setting it at a fixed dollar amount. That would maintain a substantial subsidy for employment-based coverage even when health costs rise rapidly.**

**A 2013 Urban Institute study finds that a cap set at the 75th percentile of premiums and other medical benefits offered by employers would produce \$264 billion in new revenue over 10 years while preserving 93 percent of the tax subsidies provided to workers under the current policy. Such a policy would also reduce the regressivity of the current tax treatment of employment-based insurance.**

*From Representative Tom Price of Georgia:*

Question 1:

The American people need choices and portability. We have one tax benefit that's tied to a job. And another that's tied to a broken website. We have to get money in the hands of the American people that is actually portable, that can actually be used to buy the plan of their choice, without Washington mandates and regulations increasing costs. Do you agree that one solution to provide improved portability of health coverage is to give employers the ability to provide their employees with a defined contribution so they may purchase health coverage within the individual market?

- a. Do you agree this would help to equalize the tax treatment between the employer and individual market?
- b. Do you agree that such an arrangement would encourage more employees to exit the employer market and enter the individual market?

**Response: Lack of portable health insurance has long been a problem. Although COBRA gives workers the right to continue their employment-based coverage after they leave their jobs, the worker is responsible for up to 102 percent of the total cost of the group plan. Except for short periods between jobs, this is not a long-term solution for most people because of the cost. The ACA exchanges were intended to resolve the "job lock" of workers remaining in unsuitable jobs to keep their health coverage. This has proven not to be a solution for the middle class, who are not eligible for substantial subsidies and have largely not purchased exchange health plans.**

**Workers who participate in their employer's health plan pay the full cost of that plan with pre-tax dollars, which represents about a 30 percent savings on federal income and payroll taxes and additional savings if the worker is subject to state and local income taxes. Workers who purchase insurance on the individual market rather than from their employer do not receive that tax subsidy. Under current tax rules, employees must pay taxes if they are given a cash "defined contribution" by the employer to help them buy insurance on the individual market. As a result, such defined contributions are rarely if ever provided, and most workers buy health insurance from their employers.**

**Equalizing the tax treatment of employer contributions to health insurance premiums regardless of where the coverage is purchased would result in a shift toward the individual insurance market. However, employment-based coverage would continue to be popular for some time because it is more convenient and easier to navigate for most workers. A greater shift will occur if the plan options available on the individual market are more attractive than employment-based plans and if the shopping experience improves.**

Question 2:

What can we do to encourage consumers to take a greater interest in their own healthcare costs?

**Response:** Consumers are naturally interested in (and concerned about) the out-of-pocket payments they must make for health services, which accounts for about 12 percent of total health spending. They are less aware of the payments made by insurers on their behalf or of the total cost of health care. However, consumers ultimately pay those costs as well through health insurance premiums and taxes to finance Medicare, Medicaid, and exchange subsidies.

Shifting from first-dollar coverage to high-deductible health plans with health savings accounts would make consumers more aware of the full cost of health care, and would reduce spending somewhat. The study by Lo Sasso and colleagues (*Health Services Research*, 2010) shows that HSA enrollees spent roughly 5–7 percent less than non-HSA enrollees.

More should be done to promote cost awareness. For many services, neither the patient nor the physician know in advance what the full cost or the patient's out-of-pocket share will be. Initiatives to require hospitals to post prices, for example, are claimed to improve cost awareness. But such measures overlook the complicated system of discounts and cost-sharing requirements that determine the final price to the insurer and to the patient.

To resolve this lack of information, efforts must be made jointly between providers and insurers to provide relevant cost information on a timely basis. With improvements in data processing, it soon should be possible to provide accurate and timely information on the cost of routine services and the patient's share of that cost. That will require real-time processing by the insurer to account for whether the patient has paid his deductible, whether the providers of service are in- or out-of-network, and other factors that influence the patient's out-of-pocket cost. For more complex services, a range of costs can be developed reflecting the typical experience of patients.

Patients need information on both cost and quality. More work is needed to develop reliable and understandable information about the effectiveness of alternative treatments and the ability of their providers in delivering those treatments. There is much talk about promoting value in health care, and better information with greater patient involvement is central to that effort.

#### Question 3:

How do we justify an open-ended tax benefit in the employer market, yet no tax benefit in the individual market?

**Response:** The preferential tax treatment of employment-based health insurance unfairly penalizes individuals who do not have access to good company health plans, and disadvantages low-income workers and others who are not working but need coverage. Perversely, we are providing larger subsidies to high-income workers and no subsidies to those who are outside the employer-based insurance market. Moreover, the open-ended nature of the tax break promotes wasteful spending and inefficiency in the health care system. Capping the exclusion would free up funds that could be used to provide subsidies for those purchasing individual health coverage. A more complete reform would address the uneven distribution of tax subsidies across different income groups and different insurance markets, including the exchange subsidies which are unavailable to middle-class purchasers.

#### Question 4:

Would you agree that denying Americans (especially wealthy Americans) a tax break in the individual market artificially incentivizes them to seek insurance through an employer? What's the solution?

**Response:** Under current law, workers in higher tax brackets benefit the most from the exclusion. The Joint Committee on Taxation found that the average savings for tax filers with incomes less than \$30,000 was about \$1,650 compared to about \$4,580 for those with incomes over \$200,000. Without such substantial tax benefits, the individual insurance market would have developed and the employer insurance market would not have flourished. Most employers are not in the health insurance business, and few would have wanted to add health insurance to their main activities without the tax break.

We should move to a system that provides fairer subsidies and promotes more efficient health insurance choices. One approach is to replace the tax exclusion with a refundable tax credit for everyone who purchases insurance, either from their employer or from the individual market. Under that system, an individual would receive a "defined contribution" subsidy that would allow him to decide whether to purchase more or less generous coverage and pay any additional premium above the value of the subsidy.

A step toward that reform would cap the tax exclusion and provide a tax credit to workers who choose to buy their insurance on the open market. Capping the exclusion reduces its regressivity and preserves employers' incentive to offer health coverage to their workers. This could serve as a transition to a tax credit for everyone.

#### Question 5:

If the President's health care law were repealed and the ESI exclusion was reformed such that it were no longer unlimited, what kind of complementary tax benefit could be put in place to level the playing field in the tax code between those who received employer-sponsored insurance and those who do not?

**Response:** Capping the exclusion and repealing the ACA would free up substantial funds to finance a tax credit for everyone purchasing on the individual insurance market (not just those buying through the exchanges as at present). The ACA experience shows the complexity of tying the credit to the family's income: it is often difficult to accurately predict one's income in advance, and it is difficult to correct mistakes (either under- or over-payments). An alternative is to relate the credit to a person's age, with higher subsidies for older people reflecting their greater use of health services, and family composition. Adjustments could also be made to account for regional variations in average health cost. It is essential that the credit be provided as a defined contribution to avoid biasing the decision about what kind of coverage to buy.

In addition, the tax code should equalize the treatment of contributions made to HSAs in the group and non-group markets. Currently, people purchasing a high-deductible health plan in the individual market may make contributions to an HSA that are deductible from their income taxes but not from their payroll taxes. A fair policy would allow full deductibility from both income and payroll taxes for such contributions wherever the individual buys health insurance.

#### Question 6:

What is the effect of the ESI exclusion on ESI premiums? Why? [CBO found the ESI exclusion increases average premiums for employment-based plans by 10% to 15%.]

What are the anticipated effects of capping the ESI exclusion?

**Response:** The tax exclusion subsidy encourages relatively healthy workers to buy coverage from their employer, which broadens the risk pool and tends to reduce cost per enrollee and premiums. However, the stronger effect is to encourage the purchase of more extensive coverage than workers or employers would have chosen without the subsidy. Since \$1 worth of health insurance costs less than \$0.70, at the margin workers will buy more health insurance. That is the basis for CBO's estimate that the exclusion increases average premiums for employment-based plans by 10 to 15 percent.

Capping the exclusion would reduce but not eliminate the subsidy workers receive when they purchase high-cost coverage. As a result, employment-based coverage would tend to become less extensive, average premiums would fall, and some workers would drop coverage (although many of those would purchase insurance on the individual market). The size of the effect depends on where the cap is placed.

#### Question 7:

What are the advantages of age-adjusted tax credits are preferred over means-tested tax credits?

**Response:** The ACA experience has demonstrated the difficulty of implementing income-related tax credits for health insurance. Purchasers on the exchanges are required to predict their family income more than a year in advance. An individual may be between jobs or underemployed and qualified for a subsidy when he applied for exchange coverage. But if he gets a better paying job and never notifies the exchange, he will have to repay the excessive amount of subsidies. Similarly, if income was overestimated, then the individual will be due a refund, which will be forthcoming after the tax return is filed the following year. This also means that many people who have never filed an income tax return have had to do so solely because of this subsidy system, and many are likely to have paid a tax preparer to help them through a confusing process.

In contrast, there is no uncertainty about the ages of family members. Older people would get larger subsidies reflecting their tendency to use more health services. Adjustments could also be made to account for regional cost variations, with more expensive areas receiving higher fixed payment amounts. There would be no need for a low-income person to file a tax return solely because of the credit.

The dollar amount of the exchange subsidy is difficult for purchasers to determine in advance since there is a sliding scale. In contrast, the amount of an age-adjusted credit would be presented in a simple table that does not require calculations.

Both income-related credits and age-adjusted credits would be adjusted if there is a change in family composition (such as a birth or a death). In both cases, individuals would have to report the change in a timely manner to the agency responsible for the credit. However, because the age-adjusted credit is more predictable, fewer people will have to do the paperwork necessary to correct errors in payment.

#### Question 8:

The federal government provides a tax break for mortgage interest paid—it doesn't directly pay a portion of people's mortgage bills. Likewise, why would we want to directly pay people's health insurance bills as if it were some kind of "single payer"? Why not give the option to receive a direct benefit as a tax refund, for instance?

**Response:** The ACA premium subsidies are advanceable. For most enrollees, the subsidies are paid directly to the insurer on a monthly basis rather than to the enrollee. The subsidies are also refundable, which means that an enrollee can choose to receive the payment as a refund on the following year's income tax filing instead of having them paid in advance. Because subsidy recipients are low income and would have cash flow problems paying the monthly insurance premium, the refund option is not commonly taken.

It is worth noting that many people receiving the premium subsidy would rather have less health insurance and more money to spend on food and clothing for their children. The ACA subsidy is not a general grant and cannot be used for any purpose other than coverage on the exchanges. The advance subsidy payments typically do not cover the full monthly premium. A significant number of people who qualify for the premium subsidies fail to make their share of the payment every month even when the insurer continues to pay medical bills on their behalf.

*From Representative Charles Boustany of Louisiana:*

Question 1:

Another major concern, and frankly point of confusion, is that employee contributions to their HSAs and FSAs associated with their employer-sponsored insurance coverage is included in the ACA's calculation of the "Cadillac Tax".

Mr. Antos, can you explain to me why savings for future healthcare cost needs of employees is included within a calculation that's purportedly used to indicate overly-generous health coverage?

If you can project out 1, 2, or even 5 years into full implementation of the Cadillac Tax, as currently written in the ACA... can you tell me what impact dis-incentivizing employee contributions to HSAs and FSAs will have on the larger healthcare market?

**Response:** Although the Cadillac tax is typically described as a tax on high-cost health insurance, it is based on the total cost of an employer's health benefits including HSAs, FSAs, wellness programs, and on-site medical clinics. Those costs include both the employer's contribution and the employee's contribution. Consequently, any amount contributed to an HSA or an FSA by a worker from his paycheck and by his employer is potentially subject to the tax.

If the purpose of the Cadillac tax is to discourage overly generous health coverage and give workers more "skin in the game," subjecting HSA contributions to the tax makes no sense. By definition, HSA contributions are used by the worker to pay for health expenses that are *not* paid by insurance. Every penny is the worker's own money, and the worker has clear incentives to spend that money in the best way possible. Money from such accounts does *not* promote wasteful use of health services.

**By including account contributions in the calculation, the designers of the Cadillac tax have undercut a financing mechanism that promotes efficient health care and cost-awareness. A 2010 study by Anthony Lo Sasso and colleagues in *Health Services Research* finds that HSA enrollees spent roughly 5–7 percent less than non-HSA enrollees. By making account contributions less attractive, we can expect greater health spending than would otherwise be the case, but not necessarily greater value in terms of improving patient outcomes.**

*From Representative Mike Kelly of Pennsylvania:*

Question 1:

As you know, millions of Americans decline to carry health insurance for religious or ethical reasons. Many Americans cover their medical expenses by becoming members of a health care sharing ministry (HCSM). This is not insurance but rather a form of mutual aid. Members help each other pay their medical bills in a personal, faith-filled way.

The tax code recognizes health-care sharing as a legitimate alternative to traditional insurance.

The issue is that uncertainties exist with respect to the appropriate tax treatment of these arrangements with regard to Health Savings Accounts (HSA) and deductibility.

In recognizing HCSMs in the Affordable Care Act, Congress did not update the HSA section of the code (Section 223) that effectively bars hundreds of thousands of American families from having an HSA. Because of its voluntary, non-contractual nature, membership in a HCSM probably does not qualify as health insurance for purposes of the medical expense deduction under tax code although it serves a similar function.

I believe Congress needs to clarify the tax code on these questions. As such, I've introduced legislation to correct this problem. H.R. 1752 would treat membership in a health care sharing ministry as coverage under a high deductible health plan. This bipartisan bill currently has 112 cosponsors.

Would you agree that federal tax policy should correct this oversight in current law that bars health care sharing ministry members from having access to a Health Savings Account, if they want one?

And do you agree that health care sharing should be treated like traditional health insurance for tax purposes and therefore should be deductible as a qualified medical expense on the same basis as health insurance premiums?

**Response: Health care sharing ministries are a nonprofit alternative to traditional health insurance. Members of an HCSM collectively share the cost of care for the members. Because HCSMs are typically small organizations with members sharing common ethical beliefs, they are likely to discourage wasteful use of services—unlike large impersonal insurance plans, where there is no ethical compulsion to be as efficient as possible in using health services.**

**As a general principle, any alternative to health insurance that fulfills the same function should be accorded comparable status with respect to the tax code. Making the tax treatment of HCSMs comparable to that of health insurance would encourage this more efficient approach to health financing. However, such action could lead to greater federal and state regulation. For example,**

because HCSMs are not considered insurance, they are not subject to the essential benefits rule. Efforts to treat HCSMs like traditional health insurance for tax purposes should also clarify regulatory and other issues that are involved.